

## Clear Cell Carcinoma- Not so Clear

Shah P<sup>1</sup>, Viradia D<sup>1</sup>, Gupta D<sup>1</sup>, Shah C<sup>2</sup> and Bhatt P<sup>2</sup>

<sup>1</sup>Department of Medical Gastroenterology, GCS medical college and research centre, Ahmedabad, India

<sup>2</sup>Department of Medical Gastroenterology, Mission Gastro Hospital, Ahmedabad, India

### \*Corresponding author:

Palak Shah,  
Department of Medical Gastroenterology, GCS  
medical college and research centre, Ahmedabad,  
India

Received: 16 Aug 2023

Accepted: 09 Oct 2023

Published: 17 Oct 2023

J Short Name: ACMCR

### Copyright:

©2023 Shah P. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and build upon your work non-commercially

### Citation:

Shah P, Clear Cell Carcinoma- Not so Clear. Ann Clin Med Case Rep. 2023; V11(8): 1-2

### Keywords:

Renal cell carcinoma; Clear cell carcinoma;  
Colon metastasis

## 1. Introduction

Renal cell carcinoma is one of the most common malignancies of urinary tract. Metastatic disease on index presentation is quite commonly seen. Nearly 40% of patients will develop metastases after nephrectomy, and about 10% will be diagnosed with late metastatic disease after 5 years [1]. Most metastases are located in the lungs (75%), lymph nodes (36%), bone (20%) or liver (18%) [2]. Gastrointestinal tract is very unusual location for RCC metastases. Till date less than 20 cases are reported with colonic metastases of RCC. We report a case of 70-year-old male who presented to us with colonic mass which turned out to be renal cell carcinoma metastases.

## 2. Case Summary

A 70yr old male patient with history of left sided nephrectomy for RCC 7 years ago presented to us with chief complains of abdominal pain, melena in the last 20 days. on abdominal examination, abdomen was soft, non-tender. His routine investigation was done which were notable for iron deficiency anemia and occult blood in stool was positive. He was planned for computed tomography abdomen which was suggestive of mass in transverse colon. Colonoscopy was done which showed partially lumen occluding polypoidal lesion at hepatic flexure. Colonoscopy guided biopsy was done which was suggestive of clear cells, IHC done which was positive for CD10, PAX 8. Patient was planned for transverse colectomy (Figure 1-3).

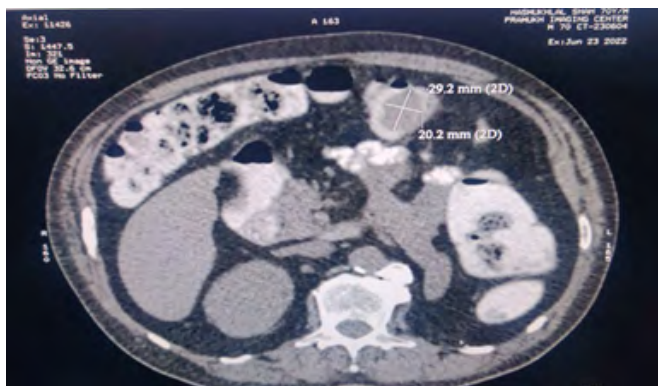


Figure 1: CECT abdomen showing mass in transverse colon

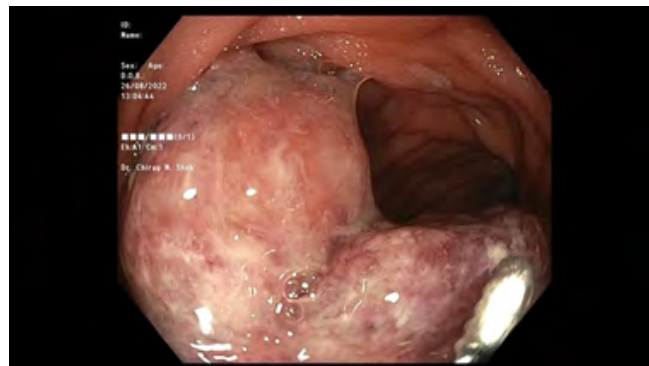
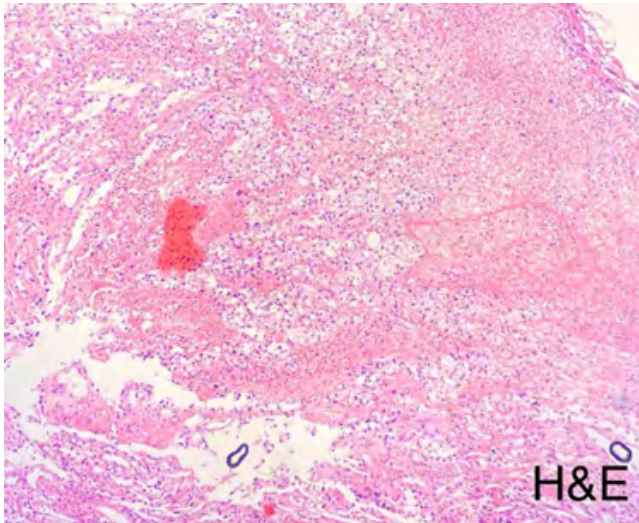


Figure 2: Colonoscopy showing partially lumen occluding polypoidal mass in transverse colon.



**Figure 3:** H&E stain showing clear cells in tissue biopsy

### 3. Discussion

RCC is most commonly seen in sixth and seventh decade of life and most commonly in men (M/F: 2/1) [3]. The tendency of RCC to unusual sites is widely reported in literature. RCC metastasis to colon is extremely rare and only few cases are reported in literature. Colonic metastasis is usually associated with disseminated disease [4]. Saitoh et al. studied 1173 autopsy reports of patients with RCC and reported intestinal involvement in 9% of cases, but none were solitary metastases [4].

Recurrent disease following curative nephrectomy occurs mainly within three years. Late recurrence after five years occurs in less than 10% of patients with recurrent disease, but is typical of colon metastasis [1,5]. There is no specific lymphatic or hematogenous pathway that can effectively explain colonic metastasis [2]. The sites of colonic metastasis also vary; although most commonly, the sigmoid, splenic flexure, transverse colon and hepatic flexure are involved. Furthermore, the prognosis for non-surgically treated disease in metastatic patients is poor [6,7].

With respect to outcome, patients with late recurrence generally have better prognosis than patients with early recurrence [1]. The pathologic features of late recurrences tend to be somewhat unique in that they are more often associated with primary tumors of T2 stage or greater, and lower histologic grade [1].

Because of the higher metastasis rate, management of the RCC requires a multidisciplinary approach. A routine postoperative surveillance is suggested by the National Comprehensive Cancer Network (NCCN) and American Urology Association (AUA). However, although there is no clear recommendation for a longer follow up period, in their assessment of 3651 operated patients, Stewart et al. showed a reduction in recurrences when patients were followed up for a longer period<sup>5</sup>. Therefore, because of the potential late RCC recurrence, postoperative surveillance may need to be extended beyond 5 years. Given the established potential for late RCC recurrence, it may be necessary to extend postoperative

surveillance beyond 5 years. Additionally, use of colonoscopy may serve as an important diagnostic adjunct in patients who develop gastrointestinal symptoms during extended RCC surveillance.

### 4. Conclusion

Patient with history of RCC and nephrectomy for same and presenting with gastrointestinal bleed should be evaluated for possibility of metastatic colonic mass. Other symptoms such as abdominal pain, anemia should also warrant for complete GI examination. Colonoscopy with tissue biopsy should be performed whenever possible.

### References

1. Fujii Y, Ikeda M, Kurosawa K, Tabata M, Kamigaito T, Hosoda C, et al. Different clinicopathological features between patients who developed early and late recurrence following surgery for renal cell carcinoma. *International journal of clinical oncology*. 2015; 20(4): 802-7.
2. Sadler GJ, Anderson MR, Moss MS, Wilson PG. Metastases from renal cell carcinoma presenting as gastrointestinal bleeding: two case reports and a review of the literature. *BMC Gastroenterol*. 2007; 7: 4.
3. Chow WH, Devesa SS, Warren JL, Fraumeni Jr JF. Rising incidence of renal cell cancer in the United States. *JAMA*. 1999; 281(17): 1628-31.
4. Saitoh H. Distant metastasis of renal adenocarcinoma. *Cancer*. 1981; 48(6): 1487-91.
5. Kavolius JP, Mastorakos DP, Pavlovich C, Russo P, Burt ME, Brady MS. Resection of metastatic renal cell carcinoma. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology*. 1998; 16(6): 2261-6.
6. Guðmundsson E, Hellborg H, Lundstam S, Erikson S, Ljungberg B; Swedish Kidney Cancer Quality Register Group. Metastatic potential in renal cell carcinomas  $\leq 7$  cm: Swedish Kidney Cancer Quality Register data. *European urology*. 2011; 60(5): 975-82.
7. Stewart SB, Thompson RH, Psutka SP, Chevillie JC, Lohse CM, Boorjian SA, et al. Evaluation of the National Comprehensive Cancer Network and American Urological Association renal cell carcinoma surveillance guidelines. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology*. 2014; 32(36): 4059-65.